

Dual Eligibles Project
Service Delivery, Finance Model, Outcomes and Quality Workgroup
September 20, 2011
Meeting Minutes 1:00-4:00 pm
Williston Fire Department

Present: Frank Reed, DMH; Ed Upson, Clara Martin Ctr.; Laura Pelosi, VHCA; Carrie Hathaway, DVHA; Michael Benvenuto, VT Legal Aid; Andy Bachand, KBS; Julie Trottier, Cathedral Square; Margaret Joyal, WCMH; Jeanne Hutchins, Center on Aging, UVM; Kathleen Denette, Dept Rate Setting; Lori Collins, DVHA; Harold Nadeau, VCIL; Lila Richardson, Healthcare Ombudsman; Sam Abel-Palmer, VT Legal Aid; Larry Goetschius, ACHHH; Stuart Graves, WCMH; Richard Slusky, DVHA; Peter Cobb, VAHHA, Marlys Waller, VT Council; Debra Lisi-Baker, Consultant; Susan Besio, PHPG; Jennifer Stratton, Lamoille VNA; Laura Driscoll, Rutland VNA; Scott Wittman, PHPG; Madeline Mongan, VT Medical Society; Bard Hill, Duals; Julie Wasserman, Duals; Patrick Flood, Duals;

Workgroups have been combined. The Financing Model and Outcomes & Quality Workgroups have been collapsed into the Service Delivery Workgroup which now meets for 3 hours. See Service Delivery Workgroup schedule for meeting dates. The Person-centered Workgroup will meet 1-2 more times before being collapsed into the larger group.

Overview of Service Delivery Design

VT needs to develop a system that is person-centered and integrated. This will require changes by some providers. The focus is on outcomes and, if successful, savings will be shared with providers. CMS also wants to share in the savings; the amount will be determined during budget discussions with VT over the next year, once the State's proposal to CMS is submitted. Services would cover the full range of Medicare and Medicaid services plus enhanced benefits for the 22,000 Dually Eligible Vermonters whose range of need varies widely. Vermont's preference is to work with its existing providers.

CMS is proposing two financial models: Capitated and Managed Fee-for-Service. VT's preference is the capitated model using VT's Medicaid Managed Care Entity (DVHA). Two approaches for receiving Medicare funds from CMS were discussed: Per member, per month (PMPM) based on historical Medicare costs for dually eligible Vermonters, and national Medicare Advantage rates that are regionally adjusted and may be more advantageous for VT. People gave examples of costs that are shifted from Medicare to Medicaid as well as Medicare cost avoidance. To do: create a list of shifted and avoided costs for future budget discussions.

Draft Schematic of Service Delivery Model

The Schematic model is a "draft" meant to stimulate discussion, ideas and input. There was a discussion of "State Manages Funds" (left side of model) and "Capitated Integrated Providers" (right side of model). The service delivery model will be linked with Blueprint efforts (medical home) and payment reform. Individuals will retain their existing PCP, and acute care needs will be managed by PCP's and specialists. "Care Coordinators"

would not be gate-keepers but rather help to integrate care and improve access to a full-range of services. Each person would be able to choose “self-management”, “provider care coordination”, or a blend of the two for their plan of care. We need to ensure that the self-management model is truly self-managed. The CFC Flexible Choices model is an excellent example of how the proposed “Individual Plans and Budgets” would work.

The following comments were made about the draft model:

- Concern was expressed about provider agencies being beholden to other provider agencies for spending authority or provision of services. Provider organizations are concerned that they need to be in control of their budgets.
- Anticipated savings would come, in part, from reduced hospital admissions and re-admissions. A question was raised about why hospitals and nursing homes would want to participate in the proposed program. One advantage for hospitals is the proposed elimination of the 3-day qualifying hospital stay.
- Eligibility and assessment processes should not be onerous or duplicative.
- The “Psychiatric/Mental Health Services” categorization within the model needs more clarification.
- VT needs to have measures and outcomes for medical, LTC and social (employment, housing, etc) indicators to ensure that people get what they need.
- Vermont will propose utilizing DVHA’s existing Grievance and Appeals Process rather than the Medicare appeals process, which would simplify the process for consumers and providers.
- Future federal cuts may erode current Medicare funding so it behooves VT providers to participate in creating a sound service delivery and financing model that can help sustain our programs even in that context.

The next meeting is scheduled for October 5th from 1:00 pm – 4:00 pm at Williston Fire Dept.